



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ECTOR COUNTY HOSPITAL DISTRICT
3255 WEST PIONEER PARKWAY
ARLINGTON, TX 76013

Respondent Name

ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box

#15

MFDR Tracking Number

M4-11-1781-01

MFDR Date Received

FEBRUARY 11, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Ector County Hospital District Medical Center to audit their Workers compensation claims. We have found in this audit you have not paid correctly according to the Hospital Fee Facility Guideline for inpatient claims. The allowable is \$7,052.81 X 143% of this amount is \$10,085.52. After your payment of \$6,408.80 and minus the PPO reduction of 10% per First Health, you have a balance due of \$2,668.17 still outstanding. **Regardless that the invoices were submitted upon first submission there is no declaration on box 80 requesting the implant charges be carved out, therefore this claim should have priced at the 143% of the Medicare allowable...**"

Amount in Dispute: \$2,668.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "A review of the EOB in this matter indicates that the bill was first reduced to the correct DRG amount multiplied by the percentage required by the rules. The total charges were \$26,007.50, and the bill review reductions were \$15,921.98, for a total of \$10,085.52. This is the same amount that Requestor indicates was the DRG x 143% as allotted. Further review of the bill allowed a PPO discount of \$3,676.72 pursuant to a Focus/First Health contract..."

Response Submitted by: Downs-Stanford, PC, 2001 Bryan Street, Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 19, 2010 Through February 21, 2010	Inpatient Hospital Surgical Services	\$2,668.17	\$2,668.17

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §133.4 sets out the guidelines for written notification to health care providers of contractual agreements for informal and voluntary networks
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated April 7, 2010

- 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. (USE GROUP CODES PR OR CO DEPENDING UPON LIABILITY).
- 100 – ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE.
- 113-001 – NETWORK IMPORT RE-PRICING – CONTRACTED PROVIDER
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- 649-002 – REIMBURSEMENT HAS BEEN CALCULATED BASED ON A DRG ALLOWANCE.

Explanation of benefits dated February 18, 2011

- 1– This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business (P303)
- 2– This bill was reviewed in accordance with your Fee for Service contract with Coventry. For questions regarding this analysis please call (800) 937-6824. (Z547)
- 3– The charge for this procedure exceeds the fee schedule allowance. (Z710)

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The insurance carrier reduced disputed services with reason code "45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. (USE GROUP CODES PR OR CO DEPENDING UPON LIABILITY)." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on March 15, 2011 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
 - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 143 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to §134.404(f)(1)(A).

3. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at <http://www.cms.gov>. Documentation found supports that the DRG assigned to the services in dispute is 512, and that the services were provided at Ector County Hospital District. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of \$7052.81. This amount

multiplied by 143% results in a MAR of \$10,085.52

4. The division concludes that the total allowable reimbursement for the services in dispute is \$10,085.52. The respondent issued payment in the amount of \$6,408.80. The requestor has asked for an additional \$2,668.17, this amount is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result the amount ordered is \$2,668.17.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$2,668.17 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	Greg Arendt	April 11, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.